Request for Administering
Prescribed Medication to a Student

Student details

First name…… Last name:……

Date of Birth……Year/Class Group:……

Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.

Name of prescribed medication:……

Prescribed for (name of medical condition):……

Prescribed dosage:……

What are you requesting the school to do? ……

……

Expiry date of the medication:……

Start date of medication:…….. End date of medication:……

Special storage requirements if any e.g. in refrigerator:……

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Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:

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Through information you have obtained from your doctor or got yourself, are you aware of any likely side effects from the prescribed medication?

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Parent or Carer Signature:…… Date:……